



Complete Summary

GUIDELINE TITLE

Special populations. Sexually transmitted diseases treatment guidelines 2002.

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention. Special populations. Sexually transmitted diseases treatment guidelines. MMWR Recomm Rep 2002 May 10; 51(RR-6):5-7.

COMPLETE SUMMARY CONTENT

SCOPE
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RECOMMENDATIONS
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SCOPE

DISEASE/CONDITION(S)

Sexually transmitted diseases (STDs) including syphilis, hepatitis B and C virus infection, Chlamydia trachomatis infection, human immunodeficiency virus (HIV) infection, gonorrhea, herpes simplex virus infection, and bacterial vaginosis

GUIDELINE CATEGORY

Counseling
Prevention
Screening

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Pediatrics

Preventive Medicine
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

- To update the 1998 Guidelines for Treatment of Sexually Transmitted Diseases (MMWR 1998; 47[No. RR-1])
- To assist physicians and other health-care providers in preventing and treating sexually transmitted diseases (STDs)
- To present updated recommendations on the screening and counseling of pregnant women, adolescents, children, and men who have sex with men for STDs

TARGET POPULATION

- Pregnant women
- Adolescents
- Men who have sex with men (MSM)
- Children with sexually transmitted diseases (STDs)

INTERVENTIONS AND PRACTICES CONSIDERED

Note from the National Guideline Clearinghouse and the Centers for Disease Control and Prevention: These guidelines focus on the treatment and counseling of individual patients and do not address other community services and interventions that are important in sexually transmitted disease/human immunodeficiency virus (STD/HIV) prevention.

Pregnant Women

1. HIV testing, serologic test for syphilis (rapid plasma reagin-card test), serologic test for hepatitis B surface antigen (HBsAg), test for hepatitis C antibodies, tests for *Neisseria gonorrhoeae* and *Chlamydia trachomatis*, evaluation for bacterial vaginosis, Papanicolaou (Pap) smear
2. Reporting of hepatitis B surface antigen-positive pregnant women to state and/or local health department for appropriate management
3. Vaccination of household and sexual contacts of hepatitis B surface antigen-positive women
4. Appropriate counseling of hepatitis C-positive women
5. Cultures for herpes simplex virus and prophylactic cesarean section (not routinely recommended)

Adolescents

1. Provision of education and counseling on the risks and consequences of sexually transmitted diseases
2. Confidential diagnosis and treatment of sexually transmitted diseases
3. Vaccination for hepatitis B

Children

1. Cooperative management involving clinicians, laboratory workers, and child-protection authorities in children with sexually transmitted diseases
2. Investigations when indicated

Men who have sex with men

1. Assessment of sexual risk for all male patients
2. Prevention counseling
3. HIV testing
4. Syphilis serology
5. Urethral culture or nucleic acid amplification test for gonorrhea
6. Urethral or urine test (culture or nucleic acid amplification) for chlamydia
7. Pharyngeal culture for gonorrhea
8. Rectal gonorrhea and chlamydia culture
9. Hepatitis A and B vaccination, with prevaccination serologic testing

MAJOR OUTCOMES CONSIDERED

Prevention of transmission of sexually transmitted diseases (STDs)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Beginning in 2000, Centers for Disease Control and Prevention (CDC) personnel and professionals knowledgeable in the field of sexually transmitted diseases (STDs) systematically reviewed literature (i.e., published abstracts and peer-reviewed journal articles) concerning each of the major STDs, focusing on information that had become available since publication of the 1998 Guidelines for Treatment of Sexually Transmitted Diseases. Background papers were written and tables of evidence constructed summarizing the type of study (e.g., randomized controlled trial or case series), study population and setting, treatments or other interventions, outcome measures assessed, reported findings, and weaknesses and biases in study design and analysis. A draft document was developed on the basis of the reviews.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Pregnant Women

Intrauterine or perinatally transmitted sexually transmitted diseases (STDs) can have severely debilitating effects on pregnant women, their partners, and their fetuses. All pregnant women and their sex partners should be asked about STDs,

counseled about the possibility of perinatal infections, and ensured access to treatment, if needed.

Recommended Screening Tests

- All pregnant women should be offered voluntary human immunodeficiency virus (HIV) testing at the first prenatal visit. Reasons for refusal of testing should be explored, and testing should be reoffered to pregnant women who initially declined testing. Retesting in the third trimester (preferably before 36 weeks' gestation) is recommended for women at high risk for acquiring HIV infection (i.e., women who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, or have HIV-infected partners). In addition, women who have not received prenatal counseling should be encouraged to be tested for HIV infection at delivery.
- A serologic test for syphilis should be performed on all pregnant women at the first prenatal visit. In populations in which use of prenatal care is not optimal, rapid plasma reagin (RPR)-card test screening (and treatment, if that test is reactive) should be performed at the time a pregnancy is confirmed. Patients who are at high risk for syphilis, are living in areas of excess syphilis morbidity, are previously untested, or have positive serology in the first trimester should be screened again early in the third trimester (28 weeks' gestation) and at delivery. Some states require all women to be screened at delivery. Infants should not be discharged from the hospital unless the syphilis serologic status of the mother has been determined at least one time during pregnancy and preferably again at delivery. Any woman who delivers a stillborn infant should be tested for syphilis.
- A serologic test for hepatitis B surface antigen (HBsAg) should be performed on all pregnant women at the first prenatal visit. HBsAg testing should be repeated late in pregnancy for women who are HBsAg negative but who are at high risk for hepatitis B virus (HBV) infection (e.g., injection-drug users and women who have concomitant STDs).
- A test for Chlamydia trachomatis should be performed at the first prenatal visit. Women aged <25 years and those at increased risk for chlamydia (i.e., women who have a new or more than one sex partner) also should be tested during the third trimester to prevent maternal postnatal complications and chlamydial infection in the infant. Screening during the first trimester might enable prevention of adverse effects of chlamydia during pregnancy. However, evidence for preventing adverse effects during pregnancy is lacking. If screening is performed only during the first trimester, a longer period exists for acquiring infection before delivery.
- A test for Neisseria gonorrhoeae should be performed at the first prenatal visit for women at risk or for women living in an area in which the prevalence of N. gonorrhoeae is high. A repeat test should be performed during the third trimester for those at continued risk.
- A test for hepatitis C antibodies (anti-HCV) should be performed at the first prenatal visit for pregnant women at high risk for exposure. Women at high risk include those with a history of injection-drug use, repeated exposure to blood products, prior blood transfusion, or organ transplants.
- Evaluation for bacterial vaginosis (BV) may be conducted at the first prenatal visit for asymptomatic patients who are at high risk for preterm labor (e.g., those who have a history of a previous preterm delivery). Current evidence does not support routine testing for bacterial vaginosis.

- A Papanicolaou (Pap) smear should be obtained at the first prenatal visit if none has been documented during the preceding year.

Other Concerns

Other STD-related concerns are as follows.

- HBsAg -positive women should be reported to the local and/or state health department to ensure that they are entered into a case-management system and that appropriate prophylaxis is provided for their infants. In addition, household and sex contacts of hepatitis B surface antigen-positive women should be vaccinated.
- No treatment is available for anti-hepatitis C virus-positive pregnant women. However, all women found to be anti-hepatitis C virus-positive should receive appropriate counseling (See the National Guideline Clearinghouse [NGC] summary of the CDC guideline [Hepatitis C, section on Prevention](#)). No vaccine is available to prevent hepatitis C virus transmission.
- In the absence of lesions during the third trimester, routine serial cultures for herpes simplex virus are not indicated for women who have a history of recurrent genital herpes. Prophylactic cesarean section is not indicated for women who do not have active genital lesions at the time of delivery.
- The presence of genital warts is not an indication for cesarean section.
- Not enough evidence exists to recommend routine screening for *Trichomonas vaginalis* in asymptomatic pregnant women.

Adolescents

Health professionals who provide care for adolescents should be aware of several issues that relate specifically to persons within this age group. The rates of many STDs are highest among adolescents. For example, the reported rates of chlamydia and gonorrhea are highest among females aged 15--19 years, and young adults are also at highest risk for human papillomavirus infection. In addition, surveillance data indicate that 9% of adolescents who have acute hepatitis B virus infection either have had sexual contact with a chronically infected person or with multiple sex partners or report their sexual preference as homosexual. As part of a comprehensive strategy to eliminate hepatitis B virus transmission in the United States, Advisory Committee on Immunization Practices has recommended that all children be administered hepatitis B vaccine.

Younger adolescents (i.e., persons aged <15 years) who are sexually active are at particular risk for infection. Adolescents at especially high risk for STDs include youth in detention facilities, STDs clinic patients, male homosexuals, and injection-drug users. Adolescents are at greater risk for STDs because they frequently have unprotected intercourse, are biologically more susceptible to infection, are engaged in partnerships often of limited duration, and face multiple obstacles to utilization of health care. Several of these issues can be addressed by clinicians who provide services to adolescents. Clinicians can address the lack of knowledge and awareness about the risks and consequences of STDs and offer guidance, constituting true primary prevention, to help adolescents develop healthy sexual behaviors and thus prevent the establishment of patterns of behavior that can undermine sexual health.

With a few exceptions, all adolescents in the United States can consent to the confidential diagnosis and treatment of STDs. Medical care for STDs can be provided to adolescents without parental consent or knowledge. Furthermore, in many states adolescents can consent to HIV counseling and testing. Consent laws for vaccination of adolescents differ by state. Several states consider provision of vaccine similar to treatment of STDs and provide vaccination services without parental consent. Health-care providers should acknowledge the importance of confidentiality for adolescents and should strive to follow policies that comply with state laws to ensure the confidentiality of STD-related services.

Despite the prevalence of STDs among adolescents, providers frequently fail to inquire about sexual behavior, assess risk for STDs, counsel about risk reduction, and screen for asymptomatic infection during clinical encounters. When addressing these sensitive areas with young people, the style and content of counseling and health education should be adapted for adolescents. Discussions should be appropriate for the patient's developmental level and should identify risky behaviors (e.g., sex and drug-use behaviors). Careful counseling and thorough discussions are particularly important for adolescents who may not acknowledge that they engage in high-risk behaviors. Care and counseling should be direct and nonjudgmental.

Children

Management of children who have STDs requires close cooperation between clinicians, laboratorians, and child-protection authorities. Investigations, when indicated, should be initiated promptly. Some diseases (e.g., gonorrhea, syphilis, and chlamydia), if acquired after the neonatal period, are almost 100% indicative of sexual contact. For other diseases (e.g., human papilloma virus infection and vaginitis), the association with sexual contact is not as clear (see the National Guideline Clearinghouse summary of the CDC guideline [Sexual Assault and STDs](#)).

Men Who Have Sex with Men

Some men who have sex with men (MSM) are at high risk for HIV infection and other viral and bacterial STDs. Although the frequency of unsafe sexual practices and reported rates of bacterial STDs and incident HIV infection has declined substantially in MSM during the last several decades, increased rates of infectious syphilis, gonorrhea, and chlamydial infection, largely among HIV-infected MSM, have been recently reported in many cities in the United States and other industrialized countries. Preliminary data also indicate higher frequencies of unsafe sex and suggest that the incidence of HIV infection may be rising among MSM in some cities. The underlying behavioral changes likely are related to effects of improved HIV/AIDS therapy on quality of life and survival, "safer sex burnout", and in some cities, adverse trends in substance abuse.

Clinicians should assess sexual risk for all male patients, which includes routinely inquiring about the sex of patients' sex partners. MSM, including those with HIV infection, should routinely undergo straightforward, nonjudgmental STDs/HIV risk assessment and client-centered prevention counseling to reduce the likelihood of acquisition or transmission of HIV and other STDs. In addition, screening for STDs should be considered for many MSM. The following screening recommendations

are based on preliminary data; these tests should be performed at least annually for sexually active MSM:

- HIV serology, if HIV-negative or not previously tested;
- syphilis serology;
- urethral culture or nucleic acid amplification test for gonorrhea;
- a urethral or urine test (culture or nucleic acid amplification) for chlamydia in men with oral-genital exposure;
- pharyngeal culture for gonorrhea in men with oral-genital exposure; and
- rectal gonorrhea and chlamydia culture in men who have had receptive anal intercourse.

In addition, vaccination against hepatitis is the most effective means of preventing sexual transmission of hepatitis A and B. Prevacination serologic testing may be cost-effective in MSM, among whom the prevalence of hepatitis A and B infection is likely to be high.

More frequent STD screening (e.g., at 3--6-month intervals) may be indicated for MSM at highest risk (e.g., those who acknowledge having multiple anonymous partners or having sex in conjunction with illicit drug use and patients whose sex partners participate in these activities). Screening tests usually are indicated regardless of a patient's history of consistent use of condoms for insertive or receptive anal intercourse. Providers also should be knowledgeable about the common manifestations of symptomatic STDs in MSM (e.g., urethral discharge, dysuria, anorectal symptoms [such as pain, pruritis, discharge, and bleeding], genital or anorectal ulcers, other mucocutaneous lesions, lymphadenopathy, and skin rash). If these symptoms are present, providers should perform appropriate diagnostic tests.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

Throughout the 2002 guideline document, the evidence used as the basis for specific recommendations is discussed briefly. More comprehensive, annotated discussions of such evidence will appear in background papers that will be published in a supplement issue of the journal *Clinical Infectious Diseases*.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Decreased incidence of intrauterine and perinatally transmitted sexually transmitted diseases (STDs) to the fetuses of pregnant women with STDs
- Decreased incidence of STDs and human immunodeficiency virus (HIV) infection among adolescents and men who have sex with men (MSM)
- Appropriate management of children with STDs

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These recommendations were developed in consultation with public- and private-sector professionals knowledgeable in the treatment of patients with sexually transmitted diseases (STDs). They are applicable to various patient-care settings, including family planning clinics, private physicians' offices, managed care organizations, and other primary-care facilities. When using these guidelines, the disease prevalence and other characteristics of the medical practice setting should be considered. These recommendations should be regarded as a source of clinical guidance and not as standards or inflexible rules. These guidelines focus on the treatment and counseling of individual patients and do not address other community services and interventions that are important in STD/HIV prevention.
- For a more detailed discussion of these guidelines, as well as infections not transmitted sexually, refer to the following references: Guide to Clinical Preventive Services, Guidelines for Perinatal Care, American College of Obstetricians and Gynecologists (ACOG) Educational Bulletin: Antimicrobial Therapy for Obstetric Patients, American College of Obstetricians and Gynecologists Committee Opinion: Primary and Preventive Care: Periodic Assessments, Recommendations for the Prevention and Management of Chlamydia trachomatis Infections, Hepatitis B Virus: A Comprehensive Strategy for Eliminating Transmission in the United States through Universal Childhood Vaccination --- Recommendations of the Immunization Practices Advisory Committee (ACIP), Mother-to-infant transmission of hepatitis C virus, Hepatitis C: Screening in pregnancy, American College of Obstetricians and Gynecologists (ACOG) Educational Bulletin: Viral hepatitis in pregnancy, Human Immunodeficiency Virus Screening: Joint statement of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists, Preventing Perinatal Transmission of HIV, and the Revised Public Health Service Recommendations for HIV Screening of Pregnant Women.
- These sources are not entirely consistent in their recommendations. The Guide to Clinical Preventive Services recommends screening of patients at high risk for chlamydia, but indicates that the optimal timing for screening is uncertain. The Guidelines for Perinatal Care recommend that pregnant women at high risk for chlamydia be screened for infection during the first prenatal-care visit and during the third trimester. Recommendations to screen pregnant women for STDs are based on disease severity and sequelae, prevalence in the population, costs, medicolegal considerations (e.g., state laws), and other factors. The screening recommendations in the guideline are

more extensive (i.e., if followed, more women will be screened for more STDs than would be screened by following other recommendations) and are compatible with other Centers for Disease Control and Prevention (CDC) guidelines.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention. Special populations. Sexually transmitted diseases treatment guidelines. MMWR Recomm Rep 2002 May 10; 51(RR-6): 5-7.

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1993 (revised 2002 May 10)

GUIDELINE DEVELOPER(S)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

GUIDELINE DEVELOPER COMMENT

These guidelines for the treatment of patients who have sexually transmitted diseases (STDs) were developed by the Centers for Disease Control and Prevention (CDC) after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta on September 26--28, 2000.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

The information in this report updates the "1998 Sexually Transmitted Diseases Treatment Guidelines" (MMWR 1998;47[No. RR-1]).

GUIDELINE AVAILABILITY

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site:

- [HTML version](#)
- [Portable Document Format \(PDF\)](#)

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Workowski KA, Levine WC, Wasserheit JN. U.S. Centers for Disease Control and Prevention guidelines for the treatment of sexually transmitted diseases: an opportunity to unify clinical and public health practice. *Ann Intern Med*. 2002 Aug 20;137(4):255-62. Electronic copies: Available through [Annals of Internal Medicine Online](#).
- Sexually Transmitted Diseases Treatment Guidelines 2002 for PDA or Palm OS. Available from the [CDC National Prevention Information Network \(NPIN\) Web site](#).

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on August 19, 2002.

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The logo for FIRSTGOV, with "FIRST" in blue and "GOV" in red, and a small red star above the "I".

